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[Date notice sent to all parties]:

12/8/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left shoulder diagnostic arthroscopy with extensive debridement, distal clavicle excision, acromioplasty, subscapularis biceps complex repair, and indicated procedure with surgical assistance.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported a work related injury on XX/XX/XX**.** The mechanism of injury occurred when the patient stepped over a limb on the ground and tripped, falling on his elbows and his knees. The initial diagnoses listed was impingement syndrome of the left shoulder and strain of the muscles and tendons of the rotator cuff of unspecified shoulder. The official MRI of the left shoulder performed on 10/09/2015 revealed articular sided partial thickness tear of the distal subscapularis at his superior margin. It was unclear if this was acute or chronic. There was medial subluxation of the long head biceps tendon from the superior most 4 mm of bicipital groove. The tendon was normally located in the mid and inferior portion of the bicipital groove. This was related to the subscapularis tear. There was chronic glenohumeral osteoarthritis with diffuse labral degeneration and degenerative irregularity of the bony glenoid. This likely explained the ill-defined abnormal signal in the cartilaginous labrum. The acromioclavicular joint was intact with no traumatic AC separation noted. There was mild chronic acromioclavicular joint

arthrosis noted and type 1 acromion. Supraspinatus, infraspinatus, and teres minor tendons were intact. There was an articular sided tear involving 75% of the tendon thickness in the distal subscapularis. There was no tendon retraction or muscle atrophy noted. The long head biceps tendon had normal morphology and signal intensity. It was normally positioned in the lower portion of the bicipital groove as well. There was medial subluxation of the tendon out of the upper most bicipital groove related to the superior supraspinatus tear. However, the biceps labral complex remained attached to the glenoid. There was an abnormal signal within the superior labrum extending posteriorly from the biceps labral complex. There was subchondral degenerative cyst formation and sclerosis involving the bony glenoid. There was no joint effusion noted, and the suprascapular notch was clear. Degenerative cysts were noted in the superior lateral humeral head. The most recent physical exam on 11/11/2015 indicates the patient presented for followup of sprain of shoulder, subluxation of shoulder joint, impingement syndrome of the shoulder region, and strain of the subscapularis tendon. The patient was in use of multiple medications to include acetaminophen 300 mg, codeine 30 mg, alprazolam 1 mg, cyclobenzaprine 10 mg, diazepam 5 mg, gabapentin 400 mg, hydrocodone 10/325 mg, Lovaza 1 gm, Nexium 40 mg, tramadol 50 mg, and multiple blood pressure medications, and cardiac medications. The patient did have a significant medical history of hypertension and heart attack. Upon physical examination, there was tenderness noted over the bicipital groove. In addition, the patient had tenderness to palpation of the subacromial bursa and the subdeltoid bursa. Active range of motion of the right shoulder was normal while active range of motion of the left shoulder was limited with forward flexion measured at 80 degrees and abduction at 40 degrees. The patient exhibited a positive Hawkins test, Neer's test, Speed's test, and subscapularis weakness noted on the left. There was also a positive drop arm test noted. External rotation on the left was noted to be 0 degrees of abduction of 4/5 and internal rotation 3/5. Neurological exam revealed sensation was intact from C5-C8, and T1-2 were also noted to be normal. The patient had normal gait and station and cranial nerves were grossly intact.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Left shoulder diagnostic arthroscopy with extensive debridement, distal clavicle excision, acromioplasty, subscapularis biceps complex repair, and indicated procedure with surgical assistance is not medically necessary. Although it is noted in the information submitted that the patient has participated in at least 3 physical therapy sessions to the left shoulder, and continues the use of multiple opioid medications, muscle relaxants, and NSAIDs, as well as an anticonvulsant medication to treat his condition, the clinical information does not provide documentation of the patient having undergone guideline recommended at least 3 months of consecutive conservative care prior to the requested surgical procedure.

Additionally, Official Disability Guidelines states that prior to undergoing surgical repair for impingement, a rotator cuff repair, extensive depression, distal clavicle excision, and biceps complex repair, patients should undergo an injection of

anesthetics for diagnostic therapeutic trial. There is no indication from the information submitted that the patient has undergone any type of anesthetic diagnostic therapeutic injection prior to the requested surgical repair.

In regard to the acromioplasty, the official MRI studies did not provide findings indicative of impingement. The study revealed a type acromion with an intact supraspinatus tendon without evidence of impingement. As to the request for a distal clavicle excision, the clinical information submitted does not provide documentation of the patient having post-traumatic changes of the AC joint or severe degenerative joint disease of the acromioclavicular joint. There was no only of mild changes noted on the official MRI study. As per Official Disability Guidelines depression is contraindicated in patients that are over the age of 60 with humeral head deformity, large osteophytes, and/or significant motion loss unless mechanical locking due to loose bodies was noted. There was no indication in the information indicating that the patient had findings of loose body noted nor has the patient had objective findings upon examination indicative of mechanical locking. The patient was noted to have humeral head deformities as evident on the MRI study.

Given the information submitted for review, the medical necessity for the requested surgical procedure(s) have not been met as criteria per the referenced guidelines has not been met for the requested surgical procedures. As such, the denial of coverage for the requested left shoulder diagnostic arthroscopy with extensive debridement, distal clavicle excision, acromioplasty, subscapularis biceps complex repair, and indicated procedure with surgical assistance is upheld.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**